STATE OF NEVADA
OFFICE OF THE ATTORNEY GENERAL
MEDICAID FRAUD CONTROL UNIT

COMPLAINT FORM

INSTRUCTIONS: Complete this form to report possible Medicaid Fraud violations by any health care provider practicing in Nevada, or any instance of abuse, neglect, isolation or exploitation of a person 60 years of age or older residing in a board and care facility. Please type or print your complaint in ink and complete the form fully. Return your original, signed form with any attachments for processing to:
Office of the Attorney General, Medicaid Fraud Control Unit, 100 North Carson Street, Carson City, NV 89701.

Thank you for taking the time to complete this form.

SECTION 1. Complainant Information:

Your Name: _____

Company (if any): _____

Mailing Address: _____

City, State, Zip: _____

Daytime Telephone: _____

SECTION 2. Complaint Description:

Name of Provider Individual: _____

Name of Provider Company: _____

Address of Provider: _____

Telephone of Provider (if known): _____

DESCRIBE IN DETAIL YOUR COMPLAINT:
(Attach additional pages if needed)

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SECTION 3. Attachments/Witnesses:

Please list additional witnesses along with any contact information for them you may have, or please list any documentation and attach to complaint you may have:

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SECTION 4. Certification:

Please sign and date this form.

I certify that the information provided on this form is true and correct to the best of my knowledge. I understand that the information may contain confidential information and that the Medicaid Fraud Control Unit is not obligated to keep such information confidential, as it may be required to disclose the information in order to process the complaint (e.g. it may be referred to another government agency that has jurisdiction over the complaint) and/or pursue an investigation or enforcement action on behalf of the state of Nevada. I also understand that the Medicaid Fraud Control Unit is not my attorney and cannot provide me with any legal advice or representation.

_____ _____

Signature Print Name

Date: _____